

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 335

## CERTIFICATE OF DEATH

Reg. Dist. No.

02910  
Reg. Dist. No. 195

1. PLACE OF DEATH: Howard  
County.....  
City or town..... Laurel Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 60 yrs.  
Hospital, institution, or street address where death occurred:  
High Ridge  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Laurel Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. High Ridge  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME <i>Rosaline H Beall</i>	3. (b) Social Security Number
---	-------------------------------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed
6. (b) Name of husband or wife Clarence Beale		
7. Birth date of deceased (mo., day, yr.)		6. (c) If alive, give age
March 11, 1872		years
8. AGE:	Years	Months
75	0	20
		If less than one day
		hrs. min.
9. Birthplace	North Carolina	
(Town, county and state)		
10. Usual occupation	Housewife	
11. Industry or business	Spongy	
12. Name	Richard King	
13. Birthplace	North Carolina	
14. Maiden name	Missouri Caroline Walker	
15. Birthplace	Missouri	

16. Informant Mrs. E. L. Wynne  
Address 9th St. Laurel, Md.  
17. Burial Date thereof April 3, 1941  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Spring Hill  
Location South End  
18. Funeral director W. H. Pitt & Son, Inc.  
Address Laurel, Md.  
42147 19. Frank Shipley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947 at 1A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1947 to March 31 1947 and that I last saw him alive on at no time 1947

Immediate cause of death

Broncho Pneumonia 1 day

Due to Influenza 3 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alpha N. Herbert M.D.  
deputy Medical Examiner, Alameda Co.

Address Fillmore City, Cal. Date signed 3-31-47

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APR 8 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

## CERTIFICATE OF DEATH

02917  
195  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Howard  
City or town Savage  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 80 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
City or town Savage  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2(a) If veteran, name war.

### 3. (a) FULL NAME

Savilla Frances Castle  
4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Emmanuel Martin Castle  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1865  
8. AGE: Years 81 Months 6 Days 20 If less than one day hrs. min.

9. Birthplace Savage, Howard, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name Joseph Bourne

13. Birthplace Anne Arundel Co., Md.

MOTHER 14. Maiden name Elizabeth Alice Sabers

15. Birthplace Baltimore, Maryland

16. Informant Elitha Phelps

Address Savage, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 30, 1947  
(month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Maryland

18. Funeral director Dr. Thitt. Donaldson

Address Laurel, Maryland

19. 3/29/47 (Date rec'd by registrar) Registrar Frank Shipley

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1947 at 12:10 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17, 1947 to March 27, 1947  
and that I last saw him alive on March 27, 1947

Immediate cause of death Chr. Myocardial Insuff.  
DURATION 1 yr.

Due to  
Due to

Other conditions Common Cold  
DURATION 1 wk.

(Include pregnancy within 3 months of death)  
Major findings of operations L

Autopsy results ✓  
Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

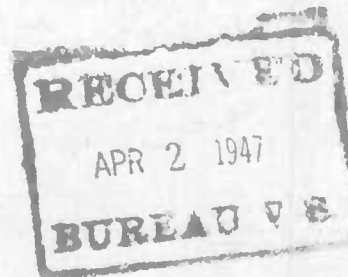
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.  
Address Savage, Md. Date signed Mar. 29, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH 166

Registered No.

193.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address. 44 mile south of Frederick Rd.
- (c) Hospital or institution: Cooksville, Howard Co., Md.
- 
- (d) Length of stay in hospital or inst. (yrs., mos., or days)-----
- (e) Length of stay in Baltimore (yrs., mos., or days)-----

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Howard
- (c) City or town Cooksville  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1/4 mile South of Frederick Rd.  
(If rural give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3 (a) FULL NAME**

- |   |   |
|---|---|
| 3 (b) If veteran, name war<br><i>None</i> | 3 (c) Social Security Account<br>No. <i>705-10-3200</i> |
|---|---|

- |                |                             |   |
|----------------|-----------------------------|---|
| 4. Sex<br>Male | 5. Color or race<br>Colored | 6 (a) Single, <u>married</u> , widowed, or divorced.<br>Married |
|----------------|-----------------------------|---|

- 6 (b) Name of husband or wife Janette  
6 (c) If alive, give age \_\_\_\_\_ years

- |   |        |      |                      |
|---|--------|------|----------------------|
| 7. Birth date of deceased (mo., day, yr.) |        |      |                      |
| 8. AGE: Years                             | Months | Days | If less than one day |
| 40  | 6      | 14   | hr. min.             |

9. Birthplace Carroll County, Ind.  
(Town, county and state)

10. Usual Occupation..... Harm hand .....

11. Industry or business *Cannine Factory*

## FATHER

- FATHER 12. Name. George Dakey  
13. Birthplace Frederick co. Md.

## MOTHER

- MOTHER
14. Maiden Name Cordelia Taylor
15. Birthplace Carroll County, Md

- 16 (a) Informant Jeanette Dancy  
(b) Address Woodbridge Md

- 17 (a) Burial (b) Date thereof 3/5/47  
(Burial, cremation, or removal) (month) (day) (year)  
(c) Cemetery or crematory Bush Park  
Location Looksville, Howard Co., Md.

- 18 (a) Funeral director H. M. Amick  
(b) Address 2212 Birch

- 19 (a) 3/5/47 (b) E. Pearl Mercier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1947, at 12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Bullet wound

- of brain

- Due to .....

- Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

- (a) Date of injury 3/2/47 at                      M.  
(b) Where did injury occur? Cooksville, Howard Co. Md.  
(c) Did injury occur at home, on farm, industrial place, in public  
place? Home While at work? No  
(d) Means of injury Firearms = (revolver)

23. Signature Howard J. Malczis M.D.  
Date signed 3/2/49 Medical Examiner.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

02919

## CERTIFICATE OF DEATH

Reg. Dist. No. 1930

1. PLACE OF DEATH: Silas W Early  
 County Howard 20 md  
 City or town Rural Florence  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rural Florence  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME Silas W Early

3. (b) Social Security Number \_\_\_\_\_

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 1871 Jan 9

8. AGE: Years 76 Months 2 Days 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery Co md  
 (Town, county, and state)

10. Usual occupation Farm

11. Industry or business Farm

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Elija Early

15. Birthplace md

16. Informant David J Early

Address Woodbine md

17. Burial Date thereof March 17 1947  
 (Burial, cremation, or removal (which?) (month) (day) (year))

Cemetery or crematory Gettysville

Location Montgomery Co md

18. Funeral director Rev W Barber

Address Gettysville md

19. 3/18 19 47 C. Dean Pierce  
 (Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 47 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 19 47 to Mar 14 19 47 and that I last saw him alive on March 13 19 47

Immediate cause of death Cancer of Rectum and Intestines DURATION 3 months

Due to unknown

Due to \_\_\_\_\_

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Ante-mortem \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results No Autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Vernon H. Dyson M. D. or other \_\_\_\_\_

Address Gettysville Date signed Mar 16/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 18 1947

BUREAU 78

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No.

02921

1950

## 1. PLACE OF DEATH:

County HarwardCity or town Savage (Rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

Snidford Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarwardCity or town Savage (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No. Snidford Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

Oscar E. Hawkins

## 3.(b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Maudie C. Hawkins6.(c) If alive, give age 61 years

7. Birth date of

deceased (mo., day, yr.)

Dec. 18, 1877

8. AGE:

Years

Months

Days

If less than one day

69222

hrs.

min.

9. Birthplace

Clarkburg, Montgomery, Md.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Plastic plant

MOTHER

FATHER

12. Name

John T. Hawkins

13. Birthplace

Cornes, Maryland

14. Maiden name

Annie Thompson

15. Birthplace

Maryland

16. Informant

Maudie C. Hawkins

Address

Savage, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 13, 1947  
(month) (day) (year)

Cemetery or crematory

Clarkburg Cemetery

Location

Clarkburg, Montgomery Co., Md.

18. Funeral director

W. H. H. Donaldson

Address

Samuel, Maryland

19.

3/12/47  
(Date rec'd by registrar)

19.

Frank Shipley  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 10<sup>th</sup> 1947 at 10-P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9<sup>th</sup> 1947 to March 10<sup>th</sup> 1947  
and that I last saw him alive on March 9<sup>th</sup> 1947

Immediate cause of death

Coronary thrombosis

DURATION

2 days

Due to

✓

Due to

✓

Other conditions

✓

(Include pregnancy within 3 months of death)

Major findings of operations

✓

Date of op.

Autopsy results

✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shipley, M.D.  
M.D. or other

Address

Savage, Md.

Date signed

3/12/47



RECEIVED

MAR 19 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County HowardCity or town West Friendship  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town West Friendship  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Ladie Putman7. Birth date of deceased (mo., day, yr.) Oct. 24, 1888 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 58 Months 5 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Agriculture12. Name Asbury L. Hobbs13. Birthplace Md.14. Maiden name Minnie D. Dorsey15. Birthplace Md.16. Informant Mrs. Ladie HobbsAddress West Friendship, Md.17. Burial Date thereof April 2, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt View CemeteryLocation Howard Co., Md.18. Funeral director C. Harry WynnAddress Lyonsville, Md.19. April 1, 1947 Alice W. Hobbs  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 4 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27 1947 to 3-30 1947 and that I last saw him alive on 3-30 1947

Immediate cause of death \_\_\_\_\_

DURATION

Pulmonary edemamyocarditis; acute; unknown.Due to subq.Due to Had been drinking for about three months.Other conditions Thromb.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

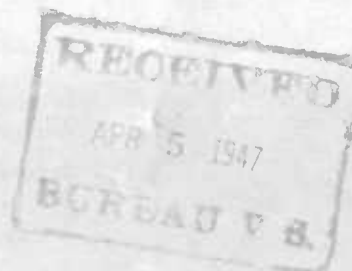
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. H. Barnes M.D.A. K. Smith M.D. M. D. or other \_\_\_\_\_Address \_\_\_\_\_ Date signed 3/31/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 456

## CERTIFICATE OF DEATH

Reg. Dist. No. 1950

## 1. PLACE OF DEATH:

County Harford  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Luther Jones  
 4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sarah P. Jones

7. Birth date of deceased (mo., day, yr.) Jan 10, 1881  
 8. AGE: Years 66 Months 2 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore County, Md.  
 (Town, county, and state)  
 10. Usual occupation Carpenter  
 11. Industry or business Construction

12. Name John L. Jones, Jr.  
 13. Birthplace Maryland

14. Maiden name Martha Ann Penney  
 15. Birthplace Maryland

16. Informant Raymond Jones  
 Address Harford, Maryland

17. Cremation Date thereof Mar. 25, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln Cemetery  
 Location Maryland

18. Funeral director Alfred H. Cavanaugh  
 Address Harford, Maryland

19. 3/24/47 19. Mar 24 1947  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22<sup>nd</sup> 1947 at 8 a.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1<sup>st</sup> 1947 to Mar. 22<sup>nd</sup> 1947 and that I last saw him alive on Mar. 30<sup>th</sup> 1947

Immediate cause of death Carcinoma of tongue

## DURATION

9 mos.Due to ✓Due to ✓Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank Shipley, M.D.

Savage, Md. M. D. or other 3/24/47  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

MAR 28 1947

RECEIVED

1-35-

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 465

## CERTIFICATE OF DEATH

02923

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Howard  
City or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
6118 old wash Rd.  
How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Howard  
City or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6118 old wash Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

George Chamney Laynor

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sadie Bauman Laynor

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1940

8. AGE: Years 76 Months 4 Days 21 It less than one day ..... hrs. .... min.

9. Birth place Baltimore city  
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Retired

12. Name Geo C. Laynor

13. Birthplace Balto md

14. Maiden name Marion Hemling

15. Birthplace Balto md

16. Informant Mrs Sadie Laynor

Address 6118 old wash Rd Elkridge

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 3/27/47  
(month) (day) (year)

Cemetery or crematory Headborough Memorial Ch.

Location Dorsey, Md

18. Funeral director John F. Lowen & Son

Address 9011-03 Holling St. - 13

19. March 25 1947 A. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947 at 8:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946 to March 24 1947

and that I last saw him alive on March 23 1947

Immediate cause of death

Myocardial infarction

Due to Coronary artery disease

Due to General arteriosclerosis

Other conditions Benignity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. W. Hedrick M. D. or other

Address Elkridge Md Date signed 3/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 193

## 1. PLACE OF DEATH:

County... Howard

City or town... Rural - Blaisy  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick

City or town... Rural Blaisy  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war... None

## 3. (a) FULL NAME

Enos Lee Main

## 3. (b) Social Security Number

None

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Susie E. Shankle Main

7. Birth date of deceased (mo., day, yr.) 1-19-1863

6. (c) If alive, give age 81 years

8. AGE: Years 84 Months 7 Days 0 hrs. min.

9. Birthplace... Frederick Co. Md.  
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... Elvied Mayne

13. Birthplace... Frederick Co., Md.

14. Maiden name... Annie Engle

15. Birthplace... Frederick Co., Md.

16. Informant... Mrs. Enos L. Main

Address... Blaisy - Maryland

17. Burial (Burial, cremation, or removal. Which?) 3-21-1947  
(month) (day) (year)

Cemetery or crematory... Rocky Springs

Location... West of Frederick - Md.

18. Funeral director... C. E. Cline &amp; Son

Address... Frederick - Md.

19. 3/21/47 E. Paul Morris  
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 19 1947 at 5:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947 to Mar. 19 1947  
and that I last saw him alive on March 18 1947

Immediate cause of death

Hemiplegia (right)

Due to... Advanced Arterio-sclerosis ? yrs

Due to...

Other conditions... Uremia - chr - ?

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op. \_\_\_\_\_

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. Stanley Grabill - M.D.

Address... M.D. - Date signed... 3/19/47

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MAR 26 1947

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1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 1910

## 1. PLACE OF DEATH:

County Howard  
City or town Waterloo  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Pedestrian  
Hospital, institution, or street address where death occurred:  
Washington Blvd, 2 mi south of  
Waterloo Road  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 456 St. Masters Personal Affairs  
division (If rural, give LOCATION)  
2.(a) If veteran, name war World War 1 + 2

## 3. (a) FULL NAME

Murray McCarty

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced DIVORCED

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 27, 1895 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 50 Months 11 Days 25 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace King George Co, Va  
(Town, county, and state)10. Usual occupation Soldier (Discharged)11. Industry or business U.S. Army12. Name LAMUEL McCARTY13. Birthplace KING GEORGE CO. VA14. Maiden name ALICE JONES15. Birthplace KING GEORGE CO. VA16. Informant FAMILY RECORDAddress 809 PRINCESS ST. ALEXANDRIA, VA.17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MARCH 25 1947  
(month) (day) (year)Cemetery or crematory ARLINGTON NATIONALLocation ARLINGTON VIRGINIA18. Funeral director J.C. Skyles & SonsAddress Elleworth City Md19. Dec 25 19 47 (Date rec'd by registrar) John B. Longhouse Registrar  
P.B.E.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 47, at \_\_\_\_\_ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1947 to March 22 1947  
and that I last saw him at no time on at no time 19 47Immediate cause of death Compound  
Fracture of Skull at  
base of brain DURATION 1 min.Due to Automobile accident  
Other conditions Compound fracture  
both legs below knee  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-22-47Where did injury occur? Waterloo (City or town) Howard (County) MD (State)Injured at home, farm, industry, public place (where?) HighwayMeans of Injury auto accident Injured at work? no

Alpha N Herbert M.D.

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address Elleworth City Md Date signed 3-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 28 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

## CERTIFICATE OF DEATH

02926

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Howard  
 City or town... Elkridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
6330 old Washington Rd.  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Howard  
 City or town... Elkridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 6330 old Wash Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Katherine Agnes Moller

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

John H Moller

7. Birth date of deceased (mo., day, yr.)

Jan 20 19656. (c) If alive, give age 86 years

8. AGE:

Years

Months

Days

It less than one day

82126

hrs.

min.

9. Birthplace

Elkridge Md  
(Town, county and state)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

12. Name

Michael Morris

13. Birthplace

Cleveland

14. Maiden name

Bridget Tibbons

15. Birthplace

Cleveland

16. Informant

Address

Mrs T.L. Bush (daughter)  
Elkridge Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

3/20/47  
(month) (day) (year)

Cemetery or crematory

St Augustines Cem.

Location

Elkridge Md.

18. Funeral director

John J. Eaven + Son

Address

901-03 Hollins St.

19.

(Date rec'd by registrar)

19

47

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 181947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1946 to March 18 1947and that I last saw him alive on March 18 1947

Immediate cause of death

Carcinomaof Sq. E. TumorCarcinomatousDue to MyocardialinfarctionDue to Senility

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B.B. Brumbaugh

M. D. or other

Address

Elkridge MdDate signed 3/18/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 105

## CERTIFICATE OF DEATH

Reg. Dist. No. 1920

## 1. PLACE OF DEATH:

County Howard  
 City or town Glenely  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 mo  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard  
 City or town Glenely  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. McHendree Road  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Florence Isabelle Powell

## 3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1946

8. AGE: Years 4 Months 0 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Glenely, Md.  
 (Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name Edward Powell

13. Birthplace Md.

14. Maiden name Florence I. Young

15. Birthplace Md.

16. Informant Edward Powell

Address Glenely, Md.

17. Burial Date thereof 3-6-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Burke Park

Location Glenwood, Md.

16. Funeral director TD/Sign. Institution

Address Emmitt City, Md.

19. March 5 1947 Alice D. Hobbs  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1947, to March 4 1947

and that I last saw her alive on at no time 1947

Immediate cause of death \_\_\_\_\_

Polar Pneumonia DURATION 2 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Alpha N. Herbert M.D.

23. SIGNATURE \_\_\_\_\_

Address Emmitt City, Md. Date signed 3-4-47

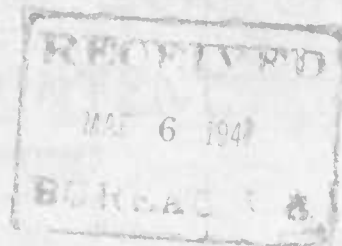
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

Reg. Dist. No. 02928 1950

### 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3.(a) FULL NAME

Frederick Walter Rowe

### 3.(b) Social Security Number

None

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Male White Single

6.(b) Name of husband or wife.....

None

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

84 7 9

9. Birthplace.....

Jessup, Md.

10. Usual occupation.....

Laborer

11. Industry or business.....

12. Name.....

Thomas Rowe

13. Birthplace.....

Maryland

14. Maiden name.....

Mary Blawette

15. Birthplace.....

Hloicester England

16. Informant.....

Mrs Helen Rowe

Address.....

Baltimore, Md.

17. Burial..... Date thereof.....

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....

Chapel Hill Cem.

Location.....

Jessup, Md.

18. Funeral director.....

Edlicott Sons

Address.....

Edlicott City, Md.

19. 3/6/47..... 19.....

(Date rec'd by registrar)..... Registrar

Mark Shigley

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 2, 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

March 2, 1947, to March 2, 1947,

and that I last saw him alive on.....

March 2, 1947.

Immediate cause of death.....

Myocardial Ischemia

DURATION.....

2 days

Due to.....

Due to.....

Other conditions.....

Serility

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Mark Shigley

Savage, Md.

Address.....

Date signed 3/6/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1947

BUREAU V. C.

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 1940

## 1. PLACE OF DEATH:

County Howard  
 City or town Highland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 minutes  
 Hospital, institution, or street address where death occurred:  
in automobile enroute to hospital  
 How long in hospital or institution? - - - - -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard  
 City or town Dayton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. - - - - -  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war - - - - -

## 3. (a) FULL NAME

EDWARD LEE SIMPSON

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife - - - - -  
 7. Birth date of deceased (mo., day, yr.) October 3, 1946 6. (c) If alive, give age - - - - - years  
 8. AGE: Years 5 Months 8 Days 8 If less than one day - - - - - hrs. - min.

9. Birthplace Ashton, Maryland  
 (Town, county, and state)  
 10. Usual occupation infant  
 11. Industry or business - - - - -  
 12. Name Charles E. Simpson  
 13. Birthplace Maryland  
 14. Maiden name Marjorie Beall  
 15. Birthplace Maryland

16. Informant Charles E. Simpson  
 Address Dayton, Md.  
 17. burial Date thereof 3-14-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Linthicum Chapel  
 Location Dayton, Md.  
 18. Funeral director F.C. Higinbotham  
 Address Ellicott City, Md.  
 19. 3-12 1947 Maria G. Whiteaker  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 47 PM 10:15  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 19 46 to March 11 19 47  
 and that I last saw him alive on March 11 19 47

Immediate cause of death Bronchopneumonia DURATION 3 days

Due to - - - - -  
 Due to - - - - -

Other conditions pemphigus neonatorum 5 mos  
malnutrition 4 mos  
 (Include pregnancy within 3 months of death)

Major findings of operations - - - - - Date of op. - - - - -

Autopsy results - - - - -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - - - - - Date of - - - - -  
 Where did injury occur? - - - - - (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) - - - - -  
 Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE Charles S. Whitaker M.D. M. D. or other - - - - -  
 Address Clarksville, Md. Date signed 3-11-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02929

RECEIVED

MAR 14 1947

BUREAU V. B.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

## CERTIFICATE OF DEATH

Reg. Dist. No. *02930* *1950*

### 1. PLACE OF DEATH:

County *Anne Arundel*  
City or town *Annapolis Junction*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *24 hrs*  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) *Howard*  
State *Md.* County *Anne Arundel*  
City or town *Annapolis Junction*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

*VALENTINE G. SPINDLER*

### 3. (b) Social Security Number

*no*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Lena M. Spindler*  
(*nee Drieslien*) 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *April 23, 1877*

8. AGE: Years *69* Months *10* Days *27* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Germany*  
(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business *Farming*

12. Name *A. P. Spindler*

13. Birthplace *Germany*

14. Maiden name *Catherine Walter*

15. Birthplace *Germany*

16. Informant *Mr. M. L. Henkel, Son-in-Law*

Address *Annapolis, Junction, Md.*

17. Burial Date thereof *3/24/47*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Loudon Park Cem.*

Location *Balto., Md.*

18. Funeral director *WM. J. TICKNER & SONS*

Address *Balto., Md.*

19. *3/21/47* 19 \_\_\_\_\_ *Frank Shipley*  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *March 20,* 19 *47* at *5<sup>00</sup> P.* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July 1<sup>st</sup> 1946* to *March 20, 1947*  
and that I last saw him alive on *March 15, 1947*

Immediate cause of death *Coronary Embolism*  
DURATION *Instant*  
Due to *Myocardial Insuff. -* *10 yrs.*

Due to \_\_\_\_\_  
Other conditions *Arterio-sclerosis* *3 yrs.*

(Include pregnancy within 3 months of death)

Major findings of operations *✓*

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *Frank Shipley, M.D.*

Address *Savage, Md.* Date signed *3/21/47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(53)

02932

## CERTIFICATE OF DEATH

Reg. Dist. No. 1940

## 1. PLACE OF DEATH:

County Howard  
 City or town Clarksville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
 City or town Clarksville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Gaither Talbott

## 3. (b) Social Security Number

—

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 13, 1925

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

21820

hrs.

min.

9. Birthplace

Baltimore Md.  
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

MOTHER FATHER

12. Name

Wm E Talbott

13. Birthplace

Md.

14. Maiden name

Lenore Dorsey

15. Birthplace

Md

16. Informant

Wm E Talbott

Address

Clarksville Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3-5-47  
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Ellicott City Md

18. Funeral director

J.C. Hignelothom

Address

Ellicott City Md.19. 3-4

(Date rec'd by registrar)

1947Maria C. Whitaker

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1947, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 11 1946 to March 3 1947and that I last saw him alive on March 3 1947

Immediate cause of death

Melanoma right ear with metastases to brain

DURATION

4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Charles S. Whitaker, M.D.

M. D. or other

Address Clarksville, Md. Date signed 3-4-47

*Reminiscences*

# ARTESIAN LEADER

240 CONTENT

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

## CERTIFICATE OF DEATH



02931

1950

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Howard  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

David Ernest Waddell

## 3. (b) Social Security Number

218-05-90994. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Mar 25, 1875-8. AGE: Years 71 Months 11 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace New Brunswick, Md.  
(Town, county, and state)10. Usual occupation Farming11. Industry or business Farm12. Name Martin Waddell13. Birthplace MD14. Maiden name unknown

15. Birthplace \_\_\_\_\_

16. Informant Mrs. Little WozeyAddress Savage, MD17. Burial Date thereof Mar 26, 47  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory SavageLocation Savage, MD18. Funeral director W. B. Smith & SonsAddress Land, MD19. 3/25/47 19. \_\_\_\_\_  
(Date rec'd by registrar)Frank Shipley  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947 at 11 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to March 22 1947 and that I last saw him alive on March 22 1947Immediate cause of death Chronic myocarditis  
DURATION 3 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert S. McConney, Jr. M. D. or other \_\_\_\_\_Address Laurie, MD Date signed March 24 1947

RECEIVED  
MAR 28 1947  
BUREAU

1-35

02933

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

## CERTIFICATE OF DEATH

Reg. Dist. No. 191-1950

## 1. PLACE OF DEATH:

County... Howard  
 City or town... Gulfport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 min.  
 Hospital, institution, or street address where death occurred:  
Jessup R.F.D.  
 How long in hospital or institution? 5 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MD County... Howard  
 City or town... Gulfport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Jessup R.F.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

CHARLES H.

WALLICH

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Ellen May Wallich  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) July 21, 1876  
 8. AGE: Years 70 Months 7 Days 24 If less than one day  
 hrs. min.

9. Birthplace... MD  
 (Town, county, and state)  
 10. Usual occupation... Retired  
 11. Industry or business  
 12. Name... Wm. Wallich  
 13. Birthplace... MD  
 14. Maiden name... Catherine Simpson  
 15. Birthplace... MD

16. Informant... Wm. Wallich  
 Address Elmwood City MD  
 17. Burial Date thereof... 3-18-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Marks  
 Location... Highland, Md.  
 18. Funeral director... H. H. Whitthorn  
 Address Elmwood City MD

19. March 17, 1947 John B. Egan  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 15 19... 47 at 2:00 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 10 19... 46 to March 12 19... 47  
 and that I last saw him alive on March 12 19... 47  
 Immediate cause of death... Myocardial infarction  
& pulmonary edema  
Chronic myocarditis  
 Due to... arteriosclerosis  
 Other conditions... diabetes mellitus  
 (Include pregnancy within 3 months of death)

DURATION  
9 months  
6 weeks  
1 year  
10 years  
4 years

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... John B. Egan MD.  
Laurel, Maryland M. D. or other  
 Date signed 3/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 22 1947  
BUREAU V \*

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